TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UT SOUTHWESTERN

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-18-0973-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 7, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: $7,657.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided outpatient surgical services to the claimant's eye without preauthorization approval from Texas Mutual. Although this is a network claim, the requestor did obtain out of network authorization to treat the claimant. However, network authorization is not the same as preauthorization of the clinical need for the procedure. Review of the operative report in the DWC60 packet does not reflect an acute emergency condition that would obviate the requirement of preauthorization. Rather, the report supports an elective, planned procedure when one notes the date of injury is [date of injury]. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
January 23, 2017	67042, 66985 and 67042(Assist surgeon)	$7,657.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. Texas Insurance Code §1305 applicable to Health Care Certified Networks.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 755 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract
   - CAC-197 – Precertification/Preauthorization/Notification absent
   - CAC-243 – Services not authorized by network/primary care providers
   - 725 – Approved non network provider for Texas Star Network claimant per Rule 1305.153 (C)
   - 727 – Provider not approved to treat Texas Star Network claimant

Issue(s)

1. Did the out-of-network healthcare provider meet the requirements of Chapter §1305.006?
2. Did the requestor obtain preauthorization for the medical services rendered on January 23, 2017?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed for CPT Codes 67042, 66985 and 67042(Assist surgeon) rendered on January 23, 2017 to an injured employee enrolled in the Texas Star Network, a certified healthcare network. The insurance carrier's response indicates that the claim is in the Texas Star Network. The requestor seeks a decision from the Division's medical fee dispute resolution (MFDR) section as an out-of-network healthcare provider.

   The insurance carrier denied/reduced the disputed charges with denial reason code "CAC-243 – Services not authorized by network/primary care provider", "727 – Provider not approved to treat Texas Star Network claimant" and "725-Aproved non network provider for Texas Star Network claimant per Rule 1305.153 (C)."

   The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation to resolve matters involving employees enrolled in a certified health care network, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 Texas Administrative Code §133.307.

   Chapter §1305.006 outlines the insurance carrier's liability for out-of-network healthcare and states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

   (1) emergency care;
   (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
   (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

   Review of the "Out of Network Authorization to Treat Injured worker Covered by the Texas Star Network", dated January 11, 2017, documents that UT Southwestern Medical Center at Clements Univ. H obtained an out-of-network referral approval to treat the in-network injured employee. The out of network referral states in pertinent part, "The request to provide necessary medical services for the above injured worker as an out of network provider has been reviewed and approved. This approval is limited specifically to the provider named above and does not extend to other associates or services within a practice group or business entity. The extent of treatment to be provided as the approved out-of-network provider is limited to the referral consultation and/or services not available within the network."

   The requestor also included a copy of a second "Out of Network Authorization to Treat Injured Worker Covered by the Texas Star Network," dated January 6, 2017, which documents that Wayne Bowman obtained an out-of-network referral approval to treat the in-network injured employee. The out of network referral states in pertinent part, "The request to provide necessary medical services for the above injured worker as an out of network provider has been reviewed and approved. This approval is limited specifically to the provider named above and does not extend to other associates or services within a practice group or business entity."

The Divisions medical fee dispute resolution section, may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network health care provider was authorized by the certified network to do so. The Division finds that the requestor has met the exception outlined in Chapter 1305.006(3). As a result, the disputed services are under the jurisdiction of the Division of Workers' Compensation and therefore, eligible for medical fee dispute resolution. The disputed services are reviewed pursuant to the applicable rules and guidelines, pursuant to Texas Insurance Code §1305.153(c).

2. The requestor billed CPT Codes 67042, 66985 and 67042(Assist surgeon) rendered on January 23, 2017. The HCN denied the disputed services with denial reason code "CAC-197 – Precertification/Preauthorization/Notification absent" and "755 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract." Review of the submitted documentation does not support that preauthorization was obtained for the medical services rendered on January 23, 2017. As a result, the requestor is not entitled to reimbursement for the disputed services.
3. The Division finds that the requestor submitted insufficient documentation to support that preauthorization was obtained for the outpatient medical services rendered on January 23, 2017. As a result, $0.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 20, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.